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Office of Administrative Law Judges
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Issue Date: 25 January 2006

In the Matter of

LARRY V. EDWARDS
Claimant

v.

FLIPPY COAL COMPANY, INC./
SECURITY INSURANCE CO. OF HARTFORD
Employer/Insurer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Case No.: 2004 BLA 46

Appearances: Mr. Ron Carson, Personal Representative
For Claimant

Mr. H. Ashby Dickerson, Attorney
For the Employer/Insurer

Before: Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER --
DENIAL OF BENEFITS

This matter involves a claim filed by Mr. Larry Edwards for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"), as implemented by 20 C.F.R. Parts 718 and 725.[1] Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

[1]Less than a year after Mr. Edwards filed his present claim, the U.S. Department issued major revisions to Parts 718 and 725. The provisions of the revised regulations applicable to Mr. Edwards claim are designated with the suffix "(2001)."

Procedural Background

First Claim

Mr. Edwards filed his first application for black lung disability benefits on July 26, 1993 (DX 29-26).[2] After a pulmonary evaluation, a claims examiner for the U.S. Department of Labor ("DOL") denied his claim for benefits on December 27, 1993 because Mr. Edwards failed to prove the presence of pneumoconiosis or total disability (DX 29-33). Mr. Edwards objected to the determination and the District Director conducted a conference (DX 29-44). After the conference, the District Director denied the claim and Mr. Edwards appealed on May 12, 1994 (DX 29-45). The case was forwarded to the Office of Administrative Law Judges (OALJ") on August 4, 1994 (DX 29-49).

On December 2, 1994, Administrative Law Judge Jeffrey Tureck conducted a hearing (DX 29-53). On March 10, 1995, Judge Tureck denied Mr. Edwards' claim because the radiographic evidence and medical opinion were insufficient to establish the presence of pneumoconiosis (DX 29-54). Mr. Edwards filed an appeal on March 24, 1995 (DX 29-55).

On October 27, 1995, the Benefits Review Board ("BRB" and "Board") affirmed Judge Tureck's denial of benefits (DX 29-60).

Second Claim

On January 10, 1997, Mr. Edwards filed his second claim for black lung disability benefits (DX 29-1). On April 7, 1997, his claim was denied due to failure to prove the presence of pneumoconiosis or total disability (DX 29-11). Following Mr. Edwards' June 3, 1997 appeal, the claim was forwarded to OALJ on August 4, 1997 (DX 20-12 and DX 29-62).

On December 16, 1997, Administrative Law Judge Edward J. Murty, Jr., conducted a hearing (DX 29-64). On February 17, 1998, Judge Murty denied Mr. Edwards' claim because he failed to establish the presence of pneumoconiosis and total disability (DX 29-65). Mr. Edwards appealed the adverse decision on February 27, 1998 (DX 29-66).

On March 9, 1999, the Benefits Review Board affirmed Judge Murty's determination that Mr. Edwards had failed to prove that he was totally disabled (DX 29- 70).

Present Claim

Initial Adjudication

On May 23, 2000, Mr. Edwards filed his third claim for benefits (DX 1). On December 8, 2000, the District Director approved his claim and initiated interim benefits since the Employer objected to the determination (DX 28). On December 12, 2000, the claim was forwarded to OALJ (DX 30 and DX 31).

[2]The following notations appear in this decision to identify exhibits: DX – Director exhibit; CX – Claimant exhibit; EX – Employer exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

First Administrative Law Judge Proceeding

On November 29, 2001, Administrative Law Judge Pamela Lakes Wood conducted a hearing (DX 46). At that time, the Employer presented an extensive medical record involving the Claimant. To permit further development of the medical evidence in light of the additional documents and provide the District Director an opportunity to consider the additional evidence, Judge Wood remanded the case to the District Director on January 4, 2002 (DX 47).

Second Adjudication

Due to the absence of an administrative law judge decision, the District Director treated the Employer's additional evidence as a request for modification. On May 7, 2002, upon additional review, the District Director denied the request and determined black lung disability benefits continued to be warranted (DX 49) On June 4, 2002, the Employer requested reconsideration due to the purported failure to evaluate all the evidence (DX 51). On November 12 and December 10, 2002, the District Director again reviewed the evidence and denied modification (DX 52 and DX 54). In January 9, 2003, the District Director returned the file to OALJ.

Second Administration Law Judge Proceeding

Following a hearing on August 8, 2003, Administrative Law Judge Steven L. Purcell again remanded the case to the District Director due to an inability to determine whether all the evidence had been submitted (DX 58).

Third Adjudication

On November 18, 2003, the District Director returned the case file to OALJ (DX 60 to 63).

Third Administrative Law Judge Proceeding

After one continuance, and pursuant to a Notice of Hearing, dated November 23, 2004, (ALJ I), I conducted a hearing on March 16, 2005 with Mr. Edwards, Mr. Carson, and Mr. Dickerson.

Evidentiary Discussion

Upon the close of the March 2005 hearing, I left the record open to provide the Employer an opportunity to respond to evidence presented by the Claimant. On April 18, 2005, Mr. Dickerson submitted a review by Dr. Long of the March 26, 2004 pulmonary function test. I now admit that evidence as EX 15.[3] A month later, Mr. Dickerson submitted a medical report by Dr. Castle in rebuttal to Dr. Forehand's pulmonary evaluation of May 3, 2004. I now admit Dr. Castle's medical report as EX 16. Accordingly, my decision in the case is based on the hearing

[3]Mr. Dickerson labeled the exhibit as "EX 14." However, EX 14 was used at the hearing to identify a May 3, 2004 pulmonary function study.

testimony and the following documents admitted into evidence: DX 1 to DX 63, CX 1 to CX 8, and EX 1 to EX 16.

Procedural Comment

Upon the first remand, the District Director treated the Employer's evidence as a request for modification. However, I note that the Employer filed a timely appeal following the District Director's initial approval of Mr. Edwards' third claim. Due to two remands, that appeal has never been adjudicated. As a result, I adjudicate this case as duplicate claim filed Mr. Edwards on May 23, 2000.

ISSUES

1. Whether in filing a duplicate claim in May 2003, Mr. Edwards has established a material change in conditions since the denial of his most recent prior claim in 1997.

2 If Mr. Edwards establishes a material change in conditions, whether he is entitled to benefits under the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulations of Fact

At the March 17, 2005 hearing, the parties stipulated that Mr. Edwards had at least 20 years of coal mine employment and Flippy Coal Company is the responsible operator (TR, pages 10 and 11).

Preliminary Findings

Born on March 9, 1950, Mr. Edwards started mining coal about 1971. For most of his mining career, and through the end of his employment with Flippy Coal Company, Mr. Edwards was a mine foreman or supervisor. As a mine foreman, Mr. Edwards was continuously on the move, lending a hand wherever his help was needed. On occasion, he would help move mining cable which involved heavy lifting. Mr. Edwards stopped mining coal in 1991 due to back and nerve problems associated with a slipped disc. Mr. Edwards started regularly smoking cigarettes when he was 18 years old. He usually smoked one to two packs of cigarettes a day. At the time of the 2005 hearing, Mr. Edwards was still smoking cigarettes at the rate of one pack a day. (DX 1 and TR, pages 19 to 38).

Issue # 1 – Material Change in Conditions

Any time within one year of a denial or award of benefits, any party to the proceeding may request a reconsideration based on a change in condition or a mistake of fact made during the determination of the claim; *see* 20 C.F.R. § 725.310. However, after the expiration of one year, the submission of additional material or another claim is considered a duplicate claim

which will be denied unless the claimant demonstrates a material change in conditions under the provisions of 20 C.F.R. § 725.309, as interpreted by the Benefits Review Board and federal Courts of Appeals. Under this regulatory provision, according to the Court of Appeals for the Sixth Circuit in *Sharondale Corp. v. Ross*, 42 F.3d 993, 997-998 (6th Cir. 1994):

> [T]o assess whether a material change is established, the ALJ must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Then, the ALJ must consider whether all of the record evidence, including that submitted with the previous claims, supports a finding of entitlement to benefits.

I interpret the *Sharondale* approach to mean that the relevant inquiry in a material change case is whether evidence developed since the prior adjudication would now support a finding of an element of entitlement. The court in *Peabody Coal Company v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997) put the concept in clearer terms:

> The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

In determining whether there has been a material change in condition, I focus on the four basic conditions, or elements, a claimant must prove by a preponderance of the evidence to receive black lung disability benefits under the Act. First, the miner must establish the presence of pneumoconiosis.[4] Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment.[5] Third, the miner has to demonstrate he is totally disabled.[6] And fourth, the miner must prove the total disability is due to pneumoconiosis.[7]

With those four principle conditions of entitlement in mind, the next adjudication step requires the identification of the conditions of entitlement a claimant failed to prove in the prior claim. In that regard, of the four principle conditions of entitlement, the only elements that are capable of changing are whether a miner has pneumoconiosis or whether he is totally disabled. *Lovilia Coal Co. v. Harvey*, 109 F.3d 445 (8th Cir. 1997). That is, the second element of

[4]20 C.F.R. § 718.202 (2001). Unlike many sections of Part 725, the provisions of Part 718 of the new regulations are applicable to pending claims.

[5]20 C.F.R. § 718.203 (a) (2001).

[6]20 C.F.R. § 718.204 (b) (2001).

[7]20 C.F.R. § 718.204 (a) (2001).

entitlement (pneumoconiosis arising out of coal mine employment) and the fourth element (total disability due to pneumoconiosis) require preliminary findings of the first element (presence of pneumoconiosis) and the third element (total disability).

Mr. Edwards' most recent, prior claim was finally denied in 1999 when the Benefits Review Board affirmed Judge Murty's finding that Mr. Edwards was not totally disabled. Consequently, for purposes of adjudicating the present duplicate claim, I will evaluate the evidence developed since the close of the record before Judge Murty in December 1997 to determine whether Mr. Edwards can now prove that he has a total respiratory disability.

Total Disability

To receive black lung disability benefits under the Act, a claimant must be totally disabled due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204 (b) and 718.304 (2001). If that presumption does not apply, then according to the provisions of 20 C.F.R. §§ 718.204 (b) (1) and (2) (2001), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. In *Beatty v. Danri Corp. & Triangle Enterprises and Dir., OWCP*, 49 F.3d 993 (3d Cir. 1995), the court stated, in order to establish total disability due to pneumoconiosis, a miner must first prove that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.

Mr. Edwards has not presented evidence of cor pulmonale with right-sided congestive heart failure and the record contains no evidence of complicated pneumoconiosis. As a result, Mr. Edwards must demonstrate total respiratory, or pulmonary, disability through arterial blood-gas studies, tests pulmonary function tests, or medical opinion.

Arterial Blood Gas Studies

Exhibit	**Date / Doctor**	**pCO^2 (rest) pCO^2 (exercise)**	**pO^2 (rest)**	**Qualified**[8]	**Comments**
DX 51	June 19, 1998 Dr. Modi	39.3	70	No[9]	

[8]To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO^2 level, the value of the coal miner's pO^2 must be equal to or less than corresponding pO^2 value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

[9]For a pCO^2 of 39, the qualifying pO^2 is 61, or less

DX 51 & DX 9	Jun. 21, 2000 Dr. Forehand	39 34	66 56	No Yes[10]	Abnormal exercise oxygenation.
DX 51 & DX 24	Sep. 11, 2000 Dr. Castle	37.4	63.2	No[11]	Mild hypoxemia
DX 59	Jun. 10, 2003 Dr. Forehand	32	81	No[12]	Normal
CX 5	May 3, 2004 Dr. Forehand	36 32	61 61	Yes[13] Yes	

At first glance, the preponderance of the arterial blood gas studies do not meet the total disability threshold. However, significantly, the two tests of Mr. Edwards' oxygen transfer capacity during exercise showed a significant impairment that passes the total disability standard. Although most of his coal mine work as a mine foreman did not involve heavy labor, Mr. Edwards testified that on occasion he assisted coal miners by lifting and moving heavy mining cable. Though infrequent, this task was nevertheless a part of his duties as a coal miner. Since the exercise arterial blood gas studies clearly demonstrate Mr. Edwards is no longer capable of accomplishing that occasional heavy labor and also satisfies the total disability requirements, I find Mr. Edwards has established total disability under 20 C.F.R. § 718.204 (b) (2) (ii) (2001).[14]

Correspondingly, based on the arterial blood gas studies developed since December 1997, Mr. Edwards has shown a material change in conditions by establishing an element of entitlement previously adjudicated against him in his prior claim. As a result, under 20 C.F.R. § 725.309, denial of his duplicate claim based on the denial of his prior claim is no longer appropriate. Instead, I will review the entire record to determine whether Mr. Edwards is able to prove all four elements necessary for entitlement of benefits under the Act; thereby establishing that he is totally disabled due to coal workers' pneumoconiosis.

Issue # 2 – Entitlement to Benefits

Again, to establish entitlement to black lung disability benefits under Act, Mr. Edwards must prove: a) the presence of pneumoconiosis; b) pneumoconiosis related to coal mine employment; c) total pulmonary disability; and, d) total disability due to coal workers' pneumoconiosis.

[10]For a pCO^2 of 34, the qualifying pO^2 is 66, or less.

[11]For a pCO^2 of 37, the qualifying pO^2 is 63, or less.

[12]For a pCO^2 of 32, the qualifying pO^2 is 68, or less.

[13]For the pCO^2 of 36, the qualifying pO^2 is 64, or less.

[14]Notably, in his closing brief, Employer's counsel indicated that he no longer contested the issue of total disability.

Pneumoconiosis

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.[15] The regulatory definitions include both clinical or medical, pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as "any chronic lung disease arising out of coal mine employment."[16] The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[17] As courts have noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. §718.202 (2001), the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202 (a)(1)), autopsy or biopsy report (§ 718.202 (a)(2)), regulatory presumption (§ 718.202 (a)(3)),[18] and medical opinion (§ 718.202 (a)(4)). Since the record does not contain sufficient evidence that Mr. Edwards has complicated pneumoconiosis,[19] and he filed his claim after January 1, 1982, a regulatory presumption of pneumoconiosis is not applicable. In addition, he has not submitted a biopsy report and the record obviously does not contain an autopsy report. As a result, Mr. Edwards will have to rely on chest x-rays or medical opinion to establish the presence of pneumoconiosis. Additionally, under the guidance of *Compton*,[20] I must consider the chest x-ray evidence and medical opinion together to determine whether a claimant can establish pneumoconiosis.

[15]20 C.F.R. § 718.201 (a) (2001).

[16]20 C.F.R. §§ 718.201 (a)(1) and (2) (2001).

[17] 20 C.F.R. § 718 (b) (2001).

[18]If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202 (a)(3) (2001), a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (2001) (if complicated pneumoconiosis is present, then there is an irrebuttable presumption that the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (2001) (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (2001) (a presumption when a survivor files a claim prior to June 30, 1982).

[19]In his interpretation of the May 3, 2004 chest x-ray, Dr. Scatarige identified a possible "1.5 nodular density" for further evaluation. However, Dr. Scatarige did not use any measurement standard, such as millimeter or centimeter, and none of the other multiple chest x-ray interpretations contained a finding of complicated pneumoconiosis.

[20]*See Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000).

Chest X-Rays

The following table summarizes all chest x-ray interpretations admitted into evidence:

Date of x-ray	**Exhibit**	**Physician**	**Interpretation**
Feb. 28, 1973	DX 51	Dr. Dodrill	Negative for pneumoconiosis; normal chest
Aug. 16, 1983	DX 51	Dr. Wheeler, BCR B[21]	Negative for pneumoconiosis; tiny infiltrate right lower lung present.
(same)	DX 51	Dr. Scott, BCR, B	Negative for pneumoconiosis; pneumonia right lower lung present.
Oct. 23, 1984	DX 51	Dr. Wheeler, BCR, B	Negative for pneumoconiosis; scar right lower lung present.
(same)	DX 51	Dr. Scott, BCR, B	Negative for pneumoconiosis; atelectasis right lower lung.
Nov. 9, 1985	DX 51	Dr. D. Patel, BCR, B[22]	No pulmonary pathology (negative for pneumoconiosis)[23]
May 8, 1987	DX 51	Dr. Shak	No evidence of any acute lung pathology (negative for pneumoconiosis)
Jul. 27, 1989	DX 51	Dr. D. Patel, BCR, B	No acute pulmonary pathology (negative for pneumoconiosis)
Dec. 6, 1991	DX 51	Dr. D. Patel, BCR, B	No acute pulmonary pathology (negative for pneumoconiosis)
Aug. 20, 1992	DX 51 & DX 29	Dr. Fino, B	Negative for pneumoconiosis; interstitial fibrosis suggested in lower lobes.
(same)	DX 51 & DX 29	Dr. Spitz, BCR, B	Negative for pneumoconiosis; linear strands at lung bases and fractures present.
(same)	DX 51 & DX 29	Dr. Wiot, BCR, B	Negative for pneumoconiosis; interstitial fibrosis, old rib fractures present.
Apr. 16, 1993	DX 51 & DX 29	Dr. Fino, B	Negative for pneumoconiosis; interstitial fibrosis present in lung bases.
(same)	DX 51 & DX 29	Dr. Spitz, BCR, B	Negative for pneumoconiosis; linear strands at lung bases and fractures present.
(same)	DX 51 & DX 29	Dr. Wiot, BCR, B	Negative for pneumoconiosis; interstitial fibrosis, old rib fractures present.
Aug. 20, 1993	DX 53 & DX 29	Dr. Gaziano, B	Positive for pneumoconiosis, profusion category 1/1,[24] type t/s opacities.[25]

[21]The following designations apply: B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs.

[22]The website for the Office of Administrative Law Judges (www.oalj.dol.gov) establishes that Dr. Patel is also a B reader.

[23]Since a physician evaluating a chest x-ray can be expected to accurately report the presence of any abnormalities, an administrative law judge may infer that the absence of a mention of pneumoconiosis indicates pneumoconiosis was not present. *See Marra v. Consolidation Coal Co.* 7 BLR 1-216, 1-219 (1985).

[24]The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very

(same)	DX 29	Dr. D. Patel, BCR, B	Positive for pneumoconiosis, profusion category 1/2, type s opacities; old rib fractures present.
(same)	DX 51 & DX 29	Dr. Wheeler, BCR, B	Negative for pneumoconiosis; healed rib fractures present.
(same)	DX 51 & DX 29	Dr. Scott, BCR, B	Negative for pneumoconiosis; healed rib fractures present.
Aug 23, 1993	DX 53, DX 51 & DX 29	Dr. Renn, B	Negative for pneumoconiosis; rib fractures present.
May 2, 1994	DX 51 & DX 29	Dr. Dahhan, B	Negative for pneumoconiosis; profusion 0/1, type s opacities present.
(same)	DX 53, DX 51 & DX 29	Dr. Scott, BCR, B	Negative for pneumoconiosis; healed rib fractures present.
(same)	DX 53, DX 51 & DX 29	Dr. Wheeler, BCR, B	Negative for pneumoconiosis; subtle infiltrate or linear fibrosis present.
(same)	DX 53, DX 51 & DX 29	Dr. Fino, B	Negative for pneumoconiosis. Interstitial fibrosis at bases.
Sep. 22, 1995	DX 51	Dr. Iyengar	No acute infiltrate, effusion, or masses (negative for pneumoconiosis)
Jan. 11, 1996	DX 51	Dr. D. Patel, BCR, B	Stable chest (negative for pneumoconiosis)[26]
May 13, 1996	DX 51	Dr. Wheeler, BCR, B	Negative for pneumoconiosis; right rib fracture present.
(same)	DX 51	Dr. Scott, BCR, B	Negative for pneumoconiosis; healed right rib fracture present.
Sep. 27, 1996	DX 51	Dr. D. Patel, BCR, B	Stable chest, no acute pulmonary pathology (negative for pneumoconiosis)

numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1 / 2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Or, a reading of 0/0 means the doctor found no, or few, opacities and didn't see any marks that would cause him or her to seriously consider category 1. According to 20 C.F.R. § 718.102 (b) (2001), a profusion of 0/1 does not constitute evidence of pneumoconiosis.

[25]There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

[26]About two and half years earlier, Dr. Patel had interpreted the August 20, 1993 chest x-ray as positive for pneumoconiosis with a 1/2 profusion. I have considered the possibility that his use of the phrase "stable chest" in his assessment of this January 11, 1996 film and the September 27, 1996 chest x-ray may indicate no worsening of the earlier noted pneumoconiosis. However, I ultimately conclude that since Dr. Patel diagnosed pneumoconiosis with precision in the August 22, 1993, I would expect him to apply the same standard in his later two evaluations if he continued to see opacities consistent with pneumoconiosis. As a result, I treat Dr. Patel's finding of "stable chest" as negative for pneumoconiosis.

Feb. 26, 1997	DX 53, DX 51 & DX 29	Dr. Cole, BCR, B	Negative for pneumoconiosis; fracture present.
(same)	DX 51 & DX 29	Dr. Forehand, B	Negative for pneumoconiosis; healed fractured rib present.
(same)	DX 51 & DX 29	Dr. Spitz, BCR, B	Negative for pneumoconiosis; fractures present.
(same)	DX 51 & DX 29	Dr. Wiot, BCR, B	Negative for pneumoconiosis; fibrosis mid lung zones present.
(same)	DX 51	Dr. Shipley, BCR, B	Negative for pneumoconiosis; fractures present.
(same)	DX 51	Dr. Scott, BCR, B	Negative for pneumoconiosis; healed rib fracture present.
Jul. 29, 1997	DX 51 & DX 29	Dr. Castle, B	Negative for pneumoconiosis; profusion 0/1, type s/t opacities; fractures present.
(same)	DX 53, DX 51 & DX 29	Dr. Scott, BCR , B	Negative for pneumoconiosis; healed rib fractures present.
(same)	DX 51 & DX 29	Dr. Wheeler, BCR, B	Negative for pneumoconiosis; healed rib fractures present.
Nov. 7, 1997	DX 51	Dr. Wheeler, BCR, B	Negative for pneumoconiosis; healed rib fracture present.
(same)	DX 51	Dr. Scott, BCR, B	Negative for pneumoconiosis; healed rib fracture present.
Nov. 22, 1997	DX 51	Dr. Wheeler, BCR, B	Negative for pneumoconiosis; healed rib fracture present.
(same)	DX 51	Dr. Scott, BCR, B	Negative for pneumoconiosis; healed rib fracture present.
Feb. 8, 1998	DX 51	Dr. Wheeler, BCR, B	Negative for pneumoconiosis; healed rib fracture present.
(same)	DX 51	Dr. Scott, BCR, B	Negative for pneumoconiosis; healed rib fracture present.
Mar. 11, 1998	DX 51	Dr. Wheeler, BCR, B	Negative for pneumoconiosis; healed rib fracture present.
(same)	DX 51	Dr. Scott. BCR, B	Negative for pneumoconiosis; healed rib fracture present.
Jun. 21, 2000	DX 12	Dr. Forehand, B	Positive for pneumoconiosis; profusion 1/1, type p opacities, questionable old rib fractures.
(same)	DX 13	Dr. Navani, BCR, B	Positive for pneumoconiosis, profusion 1/0, type p opacities; rib fractures present.
(same)	DX 51 & DX 23	Dr. Wheeler, BCR, B	Negative for pneumoconiosis; few healed rib fractures present.
(same)	DX 51 & DX 23	Dr. Scott, BCR, B	Negative for pneumoconiosis; healed rib fractures present.
Jul. 21, 2000	DX 51	Dr. Fino, B	Completely negative for pneumoconiosis.
Sep. 11, 2000	DX 51	Dr. Wheeler, BCR B	Negative for pneumoconiosis; healed rib fracture present.
(same)	DX 51	Dr. Scott, BCR, B	Negative for pneumoconiosis; healed rib fracture present.
(same)	DX 51	Dr. Fino, B	Completely negative for pneumoconiosis.
(same)	DX 51 & DX 24	Dr. Castle, B	Positive for pneumoconiosis, profusion 1/1, type s/p opacities; changes do not look like cwp.

Dec. 20, 2002	EX 7	Dr. Hallo	Clear lung fields; no acute cardiopulmonary disease noted. Several old healed rib fractures.
Jan. 22, 2003	CX 2 & CX 8	Dr. Ahmed, BCR, B	Positive for pneumoconiosis, profusion category 2/1, type p/q opacities.
(same)	EX 10	Dr. Scott, BCR, B	Negative for pneumoconiosis; healed rib fractures.
(same)	EX 11	Dr. Scatarige, BCR, B[27]	Negative for pneumoconiosis; healed rib fractures present.
May 17, 2003	DX 59	Dr. Ramakrishnan	Emphysematous lungs with chronic fibrosis, (negative for pneumoconiosis).
June 10, 2003	DX 59	Dr. Forehand, B	Diffuse reticular nodular changes (physician diagnosed coal workers' pneumoconiosis).
Apr. 1, 2004[28]	CX 1 & CX 8	Dr. Alexander, BCR, B	Positive for pneumoconiosis, profusion category 2/1, type q/t opacities.
(same)	EX 13	Dr. Scatarige, BCR, B	Negative for pneumoconiosis; healed rib fractures, emphysema, and small calcified granulomas present.
May 3, 2004	CX 3 & CX 8	Dr. Forehand, B	Positive for pneumoconiosis, profusion category 1/0, type q/p opacities.
(same)	EX 8	Dr. Scott, BCR, B	Negative for pneumoconiosis; scar lateral right side, probably healed infection.
(same)	EX 9	Dr. Scatarige, BCR, B	Negative for pneumoconiosis; emphysema present.

Of the 31 chest x-rays in the record, there is no dispute regarding 25 of the films. Based on undisputed interpretation or unanimous consensus of the interpreters, the following 24 films are negative for pneumoconiosis: February 28, 1973, August 16, 1983, October 23, 1984, November 9, 1985, May 8, 1987, July 27, 1989, December 6, 1991, August 20, 1992, April 16, 1993, August 23, 1993, May 2, 1994, September 22, 1995, January 11, 1996, May 13, 1996, September 27, 1996, February 26, 1997, July 29, 1997, November 7, 1997, November 22, 1997, February 8, 1998, March 11, 1998, July 21, 2000, December 20, 2002, and May 17, 2003. Similarly, based on a sole interpretation, the chest x-ray of June 10, 2003 is positive for pneumoconiosis.

The remaining 6 radiographic studies generated a dispute among the physicians who reviewed them. In the August 20, 1993, Dr. Gaziano, a B reader found the presence of pneumoconiosis. However, based on their better credentials as B readers and board certified radiologists, I consider the assessments of Dr. Patel, Dr. Wheeler, and Dr. Scott to be more probative.[29] Of those three experts, Dr. Patel agreed with Dr. Gaziano and believed the film was positive for black lung disease. However, the other two specialists, Dr. Wheeler and Dr. Scott, disagreed. Since two of the better qualified radiologists considered the film to be negative, I find

[27]As I advised the parties at the hearing (TR, pages 6 and 7), I take judicial notice of Dr. Scatarige's board certification and have attached the certification documentation. Additionally, the website for the Office of Administrative Law Judges (www.oalj.dol.gov) establishes that Dr. Scatarige is also a B reader.

[28]Dr. Scott determined his copy of this chest x-ray was unreadable (EX 12).

[29]*See Zeigler Coal Co. v. Director [Hawker]*, 326 F.3d 894 (7th Cir. 2003) and *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (en banc on recon.) (greater probative weight may be given to the interpretations of a dual qualified radiologist in comparison to a physician who is only a B reader).

the preponderance of the more probative medical opinions establishes that the August 20, 1993 chest x-ray is negative.[30]

The same analysis applies to the conflicting interpretations of the June 21, 2000 film. Dr. Forehand, a B reader, and Dr. Navani, a dual qualified radiologist, diagnosed the presence of pneumoconiosis. Dr. Wheeler and Dr. Scott disagreed and considered the study to be negative. Again, the consensus of Dr. Wheeler and Dr. Scott represents the preponderance of the more probative medical opinions. As a result, the June 21, 2000 chest x-ray is negative for pneumoconiosis.

While doubting the opacities were related to coal dust exposure, Dr. Castle's interpretation of the September 11, 2000 is sufficient to establish the presence of pneumoconiosis. However, his opinion is outweighed by the determinations by Dr. Wheeler and Dr. Scott, along with Dr. Fino, a B reader, that the film is negative. Thus, the September 11, 2000 chest x-ray is negative.

The three dual qualified radiologists to review the chest film of January 22, 2003 disagreed. Dr. Ahmed observed pneumoconiosis; Dr. Scott and Dr. Scatarige did not. The consensus of the later two experts establishes that the January 22, 2003 chest x-ray is negative for pneumoconiosis.

Dr. Alexander found pneumoconiosis in the April 1, 2004 chest x-ray. Dr. Scatarige did not. This evidentiary standoff between two similarly and well qualified radiographic experts renders the April 1, 2004 chest x-ray inconclusive for the presence of pneumoconiosis.

Finally, the negative interpretations of the two dual qualified radiologists, Dr. Scott and Dr. Scatarige, probatively outweigh the positive finding by Dr. Forehand, a B reader. Consequently, the May 3, 2004 chest x-ray is negative.

In summary, after setting aside the one inconclusive film from April 1, 2004, only one film from June 10, 2003 is positive for the presence of pneumoconiosis. The remaining 29 chest x-rays from February 28, 1973 through May 3, 2004 are negative for black lung disease. Accordingly, Mr. Edwards is unable to establish the presence of pneumoconiosis in his lungs through radiographic evidence under 20 C.F.R. § 718.202 (a) (1) (2001).

Medical Opinion

Although Mr. Edwards cannot establish the presence of black lung disease through chest x-ray evidence, he may still prove this requisite element of entitlement under 20 C.F.R. § 718.202 (a) (4) through the preponderance of the more probative medical opinion. To better evaluate the diverse medical opinion, a review of the other objective medical evidence in the record is helpful.

[30]I note that even if I accorded equal probative weight to Dr. Gaziano's opinion, the chest x-ray would at best be inconclusive as to the presence of pneumoconiosis.

Pulmonary Function Tests

Exhibit	Date / Doctor	Age / Height	FEV_1 pre[31] post[32]	FVC pre post	MVV pre post	% FEV_1 / FVC pre post	Qualified[33] pre post	Comments
DX 51	Aug. 20, 1991 (name illegible)	41 69”	2.87 3.12	3.33 3.49		86% 89%	No[34]	
DX 51	July 2, 1992 (name illegible)	42 69”	3.33	3.92		85%	No[35]	
DX 51 & DX 29	Aug. 20, 1993 Dr. Baxter	43 69”	3.19	4.11	101		No[36]	
DX 51 & DX 29	May 2, 1994 Dr. Dahhan	44 68”	2.47 3.13	3.52 4.12	38 52	70% 81%	No[37] No	Mild, reversible obstruction
DX 51 & DX 29	Feb. 26, 1997 Dr. Iosif	46 68”	2.81 2.85	4.14 4.20		68% 68%	No[38] No	
DX 51 & DX 29	Jul. 29, 1997 Dr. Castle	47 68”	2.91 3.03	3.93 4.04	102 94	74% 81%	No[39] No	Mild obstruction
DX 51	Jun. 21, 2000	50	2.79	4.29	69	65%	No[40]	

[31]Test result before administration of a bronchodilator.

[32]Test result following administration of a bronchodilator.

[33]Under 20 C.F.R. § 718.204 (b)(2)(i) (2001), to qualify for total disability based on pulmonary function tests, for a miner’s age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718 (2001), **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

[34]The qualifying FEV_1 number is 2.27 for age 41 and 69 inches; the corresponding qualifying FVC and MVV values are 2.84 and 91, respectively.

[35]The qualifying FEV_1 number is 2.26 for age 42 and 69 inches; the corresponding qualifying FVC and MVV values are 2.82 and 90, respectively.

[36]The qualifying FEV_1 number is 2.24 for age 43 and 69 inches; the corresponding qualifying FVC and MVV values are 2.80 and 90, respectively.

[37]The qualifying FEV_1 number is 2.13 for age 44 and 68 inches; the corresponding qualifying FVC and MVV values are 2.67 and 85, respectively.

[38]The qualifying FEV_1 number is 2.10 for age 46 and 68 inches; the corresponding qualifying FVC and MVV values are 2.63 and 84, respectively.

[39]The qualifying FEV_1 number is 2.08 for age 47 and 68 inches; the corresponding qualifying FVC and MVV values are 2.61 and 83, respectively.

[40]The qualifying FEV_1 number is 1.97 for age 50 and 67 inches; the corresponding qualifying FVC and MVV values are 2.48 and 79, respectively.

& DX 7	Dr. Forehand	67"						
DX 51 & DX 24	Sep. 11, 2000 Dr. Castle	50 69"	2.73 2.74	3.95 3.92	73	73% 70%	No[41] No	Mild obstruction (Invalid per Dr. Fino)
DX 51 & DX 45	Apr. 20, 2001 Dr. Forehand	51 67"	3.07	4.55	93	67%	No[42]	
DX 56 & EX 1	Feb. 18, 2003 (name illegible)	52 69"	4.30	5.88		73%	No[43]	Normal
DX 59	Jun. 10, 2003 Dr. Forehand	53 67"	2.37 2.89	3.92 4.35	66 90	60% 66%	No[44]	Partially reversible obstruction
CX 4	Mar. 26, 2004 (name illegible)	54 69"	2.67	4.22		63%	No[45]	Mild obstruction (Invalid per Dr. Long, no tracings, EX 15)
EX 14	May 3, 2004 Dr. Forehand	54 69"	2.93 3.08	4.67 4.89	89 86	62.7% 62.9%	No No	87% of normal

Arterial Blood Gas Studies

Exhibit	**Date / Doctor**	**$_pCO_2$ (rest) $_pCO_2$ (exercise)**	**$_pO_2$ (rest) $_pO_2$ (exercise)**	**Qualified**	**Comments**
DX 51	Mar. 8, 1987 (hospital)	41	75.3	No[46]	
DX 51 & DX 29	Aug. 20, 1993 Dr. Baxter	33 34	71 76	No[47] No	
DX 51 &	May 2, 1994	35.3	79.8	No[48]	Normal

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[41]The qualifying FEV_1 number is 2.13 for age 50 and 69 inches; the corresponding qualifying FVC and MVV values are 2.68 and 85, respectively.

[42]The qualifying FEV_1 number is 1.96 for age 51 and 67 inches; the corresponding qualifying FVC and MVV values are 2.47 and 78, respectively.

[43]The qualifying FEV_1 number is 2.10 for age 52 and 69 inches; the corresponding qualifying FVC and MVV values are 2.64 and 84, respectively.

[44]The qualifying FEV_1 number is 1.92 for age 53 and 67 inches; the corresponding qualifying FVC and MVV values are 2.43 and 77, respectively.

[45]The qualifying FEV_1 number is 2.06 for age 54 and 69 inches; the corresponding qualifying FVC and MVV values are 2.61 and 83, respectively.

[46]For a pCO^2 of 40 to 49, the qualifying pO^2 is 60, or less.

[47]For a pCO^2 of 33, the qualifying pO^2 is 67, or less.

[48]For a pCO^2 of 35, the qualifying pO^2 is 65, or less.

DX 29	Dr. Dahhan	34.1	89.5	No	
DX 51	Sep. 22, 1995 (hospital)	34.1	71.8	No	
DX 51	Jan. 11, 1996 (hospital)	38.5	70.4	No[49]	
DX 51	Jun. 20, 1996 Dr. Modi	39.4	76.6	No	
DX 51	Sep 27, 1996 (hospital)	42.2	68	No	
DX 51	Nov. 1, 1996 (hospital)	39.6	67	No	
DX 51	Jan. 8, 1997 (illegible)	38.6	66	No	
DX 51 & DX 29	Feb. 26, 1997 Dr. Iosif	38.5	62.9	No	
DX 51 & DX 29	Jul. 29, 1997 Dr. Castle	34.3 34.6	68 84	No No	

CT Scan
(DX 45 and DX 51)

Upon evaluation of a CT scan taken on March 6, 2001 to evaluate Mr. Edwards' complaint of shortness of breath, Dr. Basim Antoun stated "the lungs are clear without masses or lesions demonstrated."

Medical Evaluations[50]

Dr. Robert F. Baxter
(DX 29 and DX 51)

After Mr. Edwards' back injury in the coal mines in September 1977, Dr. Baxter began treating him for back problems and eventually other ailments. Most of Mr. Edwards' medical issues were non-pulmonary in nature. However, between May 26 and June 1, 1992, Dr. Baxter hospitalized Mr. Edwards in part due to complaints of shortness of breath, smothering, weakness and lethargy. Upon physical examination, Dr. Baxter heard coarse expiratory rhonchi and moist rales at both lung bases. Upon improvement, Mr. Edwards was discharged. Dr. Baxter's discharge diagnoses included tobacco abuse and acute respiratory distress.

On August 23, 1993, Dr. Baxter conducted a pulmonary examination. Mr. Edwards complained about worsening shortness of breath. He last mined coal in 1991 as a foreman. He

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[49]For a pCO^2 of 38, the qualifying pO^2 is 62, or less.

[50]Although I have reviewed over 800, and at times repetitive, pages of Mr. Edwards' medical record since 1973 submitted by Employer's counsel and contained in DX 45 and DX 51, I have only summarized the tests, treatments and evaluations that are relevant to his pulmonary condition. I note that some physical examination records occasionally indicated the presence of periodic wheezes. One physician in 1991 also included a diagnosis of acute bronchitis. Reports of Mr. Edwards' daily cigarette consumption varied and ranged from one to three packs of cigarettes a day.

also smoked cigarettes for 20 years at the rate of a pack a day. Upon physical examination, Dr. Baxter found distant chest sounds. The chest x-ray interpretation by Dr. Patel was positive for pneumoconiosis. Neither the pulmonary function tests nor the arterial blood gas studies reached the total disability thresholds. Dr. Baxter diagnosed coal workers' pneumoconiosis based on Mr. Edwards' exposure to coal dust for 20 years and the positive chest x-ray. Mr. Edwards' pulmonary problems, including COPD (chronic obstructive pulmonary disease), were due to his long term exposure to both coal dust and cigarette smoke. According to Dr. Baxter, Mr. Edwards' exposure to coal dust was a major contributing factor, while cigarette smoking made it worse. Due to radiographic evidence of pneumoconiosis, Mr. Edwards was not able to return to coal mining. Mr. Edwards' back problems were also disabling.

In response to an October 1993 inquiry, Dr. Baxter provided additional comments about his pulmonary examination of Mr. Edwards. According to Dr. Baxter:

> This patient has coal workers' pneumoconiosis documented on chest x-ray and would not be able to return to his former employment because he should avoid any further exposure. His ABG's and PFS do not document total disability due to lung disease, but he should avoid further exposure to coal dust to prevent any increase in lung impairment. He does have chronic lumbar radicular syndrome with right sciatica which contributes to his disability. Therefore, his total disability is due to other factors as well as his lung disease. His lung disease alone would not cause a total disability, although it would prevent him from returning to his former employment.

Dr. Abdul Dahhan
(DX 29, DX 51 and DX 53)

On May 4, 1994, Dr. Dahhan, board certified in pulmonary medicine and internal medicine, evaluated Mr. Edwards' pulmonary condition. Mr. Edwards had 20 years of coal mine employment and had smoked cigarettes at the rate of a pack a day since he was 18 years old. Upon physical examination, the chest breath sounds were good. The chest x-ray showed a few irregular opacities that were insufficient for a diagnosis of pneumoconiosis. The arterial blood gas study was normal. With a less than optimal effort in the pulmonary function tests, Mr. Edwards had a mild reversible pulmonary obstruction. Dr. Dahhan concluded Mr. Edwards was not totally disabled due to a pulmonary impairment. Mr. Edwards also did not have coal workers' pneumoconiosis. Dr. Dahhan diagnosed chronic bronchitis due to Mr. Edwards' 26 pack year history of cigarette smoking.

On October 11, 1994, Dr. Dahhan conducted a review of Mr. Edwards' medical treatment and pulmonary evaluation record from 1980 through 1993. Based on negative chest x-rays, normal arterial blood gas studies, and the absence of a restrictive ventilatory defect, Dr. Dahhan opined Mr. Edwards did not have pneumoconiosis. The obstructive pulmonary defect present in the pulmonary function tests and Mr. Edwards' 26 pack year history of cigarette smoke warranted a diagnosis of chronic bronchitis due to cigarettes. While Mr. Edwards may be unable to work due to his back problems, Dr. Dahhan believed Mr. Edwards was not totally disabled in terms of pulmonary function.

In a November 21, 1994 deposition, Dr. Dahhan discussed his May 2, 1994 pulmonary examination of Mr. Edwards. Mr. Edwards left coal mining after 20 years due to back problems. He started smoking cigarettes when he was 18 and continued to the time of the examination as evidenced by the carboxyhemoglobin level of 6.9%, which is consistent with a one pack of cigarettes per day consumption. Dr. Dahhan also noted that cigarette smoking causes an obstructive pulmonary condition. At the time of the examination, Mr. Edwards was taking medication for an ulcer and nerves. Mr. Edwards complained about chronic shortness of breath, sputum production, and wheezing, which are characteristic of bronchitis. Although Mr. Edwards completed the pulmonary function tests with less than optimum effort, Dr. Dahhan considered the post-bronchodilator test to be valid. Dr. Dahhan also reviewed Dr. Baker's August 20, 1993 tests of Mr. Edwards' pulmonary functions. These test were essentially normal; neither a restrictive nor obstructive impairment was identified. The chest x-ray from Dr. Dahhan's examination was negative for coal workers' pneumoconiosis. At the same time, Dr. Dahhan observed irregular opacities that are most frequently caused by cigarette smoke. Likewise, both the rest and exercise arterial blood gas studies were normal. Based on the clinical finding from his examination and Dr. Baker's evaluation, Dr. Dahhan concluded Mr. Edwards did not have coal workers' pneumoconiosis. He also is not totally disabled due to a respiratory impairment. According to Dr. Dahhan, Mr. Edwards has chronic bronchitis unrelated to coal dust exposure which is also not disabling.

Dr. Vinod Modi
(DX 51)

Between February 1 to 3, 1996, Dr. Modi hospitalized Mr. Edwards for severe shortness of breath and chest pain. Mr. Edwards was a retired coal miner who smoked up to two pack of cigarettes a day. The physical examination disclosed coarse inspiratory rales and rhonchi. Dr. Modi diagnosed acute bronchitis.

Dr. German Iosif
(DX 29 and DX 51)

On February 26, 1997, Dr. Iosif, board certified in immunology and pediatrics, examined Mr. Edwards. Mr. Edwards had been a coal miner for 20 years when he stopped working in 1991. During his career, he suffered a back injury. His cigarette smoking history also covered 20 years at the rate of one pack per day. The chest examination was normal and the chest x-ray was negative for pneumoconiosis. The pulmonary function study indicated the presence of a mild obstruction. Likewise, mild resting hypoxemia was established by the arterial blood gas study. Dr. Iosif found no clinical or radiographic evidence of coal workers' pneumoconiosis. Dr. Iosif also concluded that Mr. Edwards was not totally disabled from a respiratory perspective.

Clinch Valley Medical Center – Various Physicians
(EX 4, EX 5, EX 6, and EX 7)

On three occasions from April 2001 to October 2003, Mr. Edwards was treated for various non-pulmonary ailments, including radiating low back pain. The physicians reported the

Mr. Edwards was smoking one to two pack of cigarettes per day. All three chest exams associated his treatment were clear. A 2002 chest x-ray showed no evidence of an acute cardiopulmonary disease.

Dr. John Randolph Forehand
(DX 8, DX 51, DX 59, CX 6 to CX 8, and EX 14)

On June 21, 2000, Dr. Forehand, board certified in pediatrics and immunology, conducted a pulmonary evaluation. At that time, Mr. Edwards complained about shortness of breath upon exertion. Mr. Edwards had mined coal for 23 years and smoked cigarettes at the rate of one pack per day since 1970. He complained about shortness of breath upon exercise. During the physical examination, Dr. Forehand reported normal breath sounds. The chest x-ray was positive for pneumoconiosis. The pulmonary function study revealed an obstructive ventilatory pattern. The arterial blood gas test indicated hypoxemia upon exercise. Based on the examination, work history, positive chest x-ray, and arterial blood gas studies, Dr. Forehand diagnosed coal workers' pneumoconiosis due to coal dust exposure. The pulmonary function test led to Dr. Forehand's conclusion that Mr. Edwards also had chronic bronchitis due to cigarette smoking. The arterial blood gas study showed Mr. Edwards had insufficient oxygen transfer capacity to return to coal mining. As a result, he was permanently and totally disabled. Concerning the cause of the pulmonary impairment, Dr. Forehand stated: "The principal factor impairing lung function is coal workers' pneumoconiosis (23 years underground, positive chest x-ray, exercise hypoxemia). Chronic bronchitis is a minor secondary factor with little effect (mild obstruction)."

On June 10, 2003, Dr. Forehand evaluated Mr. Edwards who had coal workers' pneumoconiosis and ongoing shortness of breath. The physical examination disclosed diminished breath sounds and crackles in the left lung base. The chest x-ray showed diffuse reticular nodular changes. Although the arterial blood gas study was normal, the pulmonary function test showed hyperinflation, air-trapping, an obstructive respiratory pattern and a 22% response to bronchodilator therapy. Dr. Forehand diagnosed coal workers' pneumoconiosis.

On May 3, 2004, Dr. Forehand again examined Mr. Edwards. Dr. Forehand noted Mr. Edwards' cigarette smoking history of 35 pack years and 23 years of coal mine employment. Mr. Edwards reported chronic and worsening shortness of breath upon exertion. Upon physical examination, Dr. Forehand heard crackles in both lung bases. The chest x-ray was positive for pneumoconiosis. The pulmonary function test results were within 87% of normal. The arterial blood gas study showed abnormal oxygenation upon exercise. Based on Mr. Edwards' occupational history, the chest x-ray, and the pattern of the respiratory impairment, Dr. Forehand stated the "most likely" explanation for Mr. Edwards' worsening exertional shortness of breath was coal workers' pneumoconiosis. He found "little reason to blame cigarette smoking as the principal cause of Mr. Edwards' shortness of breath." Dr. Forehand was able to make the distinction because cigarette smoking causes emphysema identifiable by chest x-ray and abnormal pulmonary function test results, which were not present in Mr. Edwards' case. Finally, in light of the arterial blood gas study, Dr. Forehand opined Mr. Edwards suffered a permanent and total respiratory impairment.

Dr. Gregory J. Fino
(DX 29, DX 45, DX 51 and EX 2)

On November 7, 1994, Dr. Fino, board certified in pulmonary disease and internal medicine, conducted a review of the radiographic, treatment and pulmonary evaluation record of Mr. Edwards from 1978 through 1994. The chest x-ray interpretations were predominantly negative for pneumoconiosis. The arterial blood gas studies were normal. When Mr. Edwards made a good effort such that the tests were valid, his pulmonary function tests did not show either a restrictive or obstructive impairment. The physical examinations of the chests were also usually normal. Based on this medical evidence, Dr. Fino concluded Mr. Edwards did not have pneumoconiosis and was not totally disabled due to any pulmonary impairment.

On October 29, 2001, Dr. Fino conducted a review of medical treatment records and pulmonary examinations of Mr. Edwards from 1978 through September 2000. After noting Mr. Edwards' cigarette smoking history and coal mine employment history, Dr. Fino stated that he couldn't disagree with Dr. Castle's September 2000 conclusion that Mr. Edwards was developing bronchiolitis due to cigarette smoking. Although Dr. Fino did not observe irregular opacities when he interpreted the September 2000 chest x-ray, he indicated that Dr. Castle's radiographic interpretation coupled with deteriorating arterial blood gas test results and a pulmonary obstruction supported a diagnosis of bronchiolitis. Dr. Fino also concurred that due to an oxygen transfer abnormality, Mr. Edwards was totally disabled. However, that disability was not related to coal dust exposure. Dr. Fino stressed that Mr. Edwards' diminishing respiratory capacity has occurred long after he left coal mining but while he continued to smoke cigarettes. According to Dr. Fino, "The fact that it has appeared only after he last worked in the mines is consistent with an interstitial process. . . related to the bronchiolitis. . . a result of cigarette smoking."

On April 4, 2004, Dr. Fino again considered Mr. Edwards' case in light of Dr. Forehand's June 2003 pulmonary function examination. He noted a continued interstitial pattern on the chest x-ray and pulmonary function tests which showed an obstructive abnormality with a reversible component. Based on his prior review of the medical record, and in light of the new evidence, Dr. Fino remained convinced that Mr. Edwards did not have coal workers' pneumoconiosis. Dr. Fino attributed Mr. Edwards' totally disabling arterial blood gas impairment to "smoker's bronchiolitis."

Dr. James R. Castle
(DX 24, DX 29, DX 38, DX 51, DX 53, EX 3, EX 16)

On July 29, 1997, Dr. Castle, board certified in pulmonary disease and internal medicine, reviewed Mr. Edwards' medical record from 1978 to 1997 and conducted a pulmonary evaluation. Mr. Edwards complained about chronic shortness of breath and periodic chest pain. He had a 20 pack year history of cigarette smoking and 20 years of coal mine employment. Upon physical examination, the chest sounds were normal. The chest x-ray was negative for pneumoconiosis. The pulmonary function study indicated a very mild obstruction and the blood gas study showed mild resting hypoxemia. Based on his review and examination, Dr. Castle concluded Mr. Edwards was not totally disabled due to a pulmonary disability and did not have

coal workers' pneumoconiosis. Dr. Castle diagnosed tobacco smoke induced chronic bronchitis and pulmonary emphysema. Dr. Castle observed that when coal workers' pneumoconiosis is present, it causes a mixed, irreversible obstructive and restrictive pulmonary defect. Mr. Edwards' pulmonary studies did not show that type of defect.

On September 11, 2000, in addition to reviewing other pulmonary examinations from 2000 and his prior 1997 evaluation of Mr. Edwards, Dr. Castle conducted another pulmonary evaluation. At that time, Mr. Edwards reported struggling for ten years with shortness of breath upon exertion. He was a former coal miner with 23 years in the mines. Mr. Edwards' cigarette smoking history equaled 32 pack years.[51] Upon physical examination, Dr. Castle heard coarse breath sounds. The pulmonary function study showed mild obstruction and the arterial blood gas test revealed mild hypoxemia. Although Dr. Castle found the chest x-ray to have a profusion of 1, he did not believe the opacities looked like coal workers' pneumoconiosis. Instead, the radiographic evidence was consistent with interstitial pneumonitis. Dr. Castle opined that Mr. Edwards had a permanent and total disability associated with his diminished pulmonary function. Specifically, based on the arterial blood gas study, Dr. Castle opined Mr. Edwards would not be able to return to coal mining. However, due to the "very rapid" development of Mr. Edwards' pulmonary problem since 1997, coupled with the absence of coal dust exposure during that period, Dr. Castle concluded Mr. Edwards was struggling with interstitial pneumonitis rather than coal workers' pneumoconiosis.

In a May 8, 2001 deposition, Dr. Castle stated that during his evaluations of Mr. Edwards' pulmonary condition, he relied upon the regulatory definition for coal workers' pneumoconiosis. Dr. Castle examined Mr. Edwards in 1997 and 2000. In 1997, Mr. Edwards indicated that he had mined coal for 20 years but stopped due to back and breathing problems. At the time of the examinations, he was using an inhaler and complained about chronic shortness of breath upon exertion. He had a 20 pack year history of cigarette smoking. The chest x-ray revealed a few irregular linear opacities in the lower lung zones. Dr. Castle did not find the film established the presence of pneumoconiosis. Coal workers' pneumoconiosis appears as regular rounded opacities in the upper lung zones. Only in severe case will the opacities progress to the middle and lower zones. The pulmonary function test indicated a mild obstruction with a mild reduction in diffusion capacity, without restriction or air trapping. The exercise blood gas was normal. Other blood work confirmed a pack a day cigarette smoking habit. Based on the examination, Dr. Castle concluded Mr. Edwards was not totally disabled due to coal workers' pneumoconiosis. Although Dr. Castle acknowledged that coal workers' pneumoconiosis is a progressive disease, he stated, "It would be virtually impossible for him to develop it after" 1997 "in the absence of further exposure." When Dr. Castle examined Mr. Edwards in 2000, he had the same pulmonary complaints. The physical examination revealed coarse breath sounds and bilateral wheezes. The chest x-ray revealed more opacities in both the lower and middle lung lobes. That increase is consistent with Mr. Edwards' continued use of cigarettes. The pulmonary function test again showed a mild obstruction with perfusion mismatch and no restriction, which is inconsistent with coal workers' pneumoconiosis. The resting arterial blood gas produced poorer results in comparison to the 1997 findings. However, the exercise blood gas result was better than the 1997 exercise test. Nevertheless, based on the more recent blood gas studies, Mr. Edwards is probably totally disabled. The disability is not related to coal dust

[51]A pack year equals the consumption of one pack of cigarettes per day for one year.

exposure. Any deterioration was not associated with coal dust since Mr. Edwards had not engaged in coal mining between 1997 and 2000.

On April 14, 2004, Dr. Castle conducted an extensive medical record review and considered radiographic interpretations, pulmonary function test, arterial blood gas studies, hospitalization records, and pulmonary examinations from 1973 through Dr. Forehand's June 2003 evaluation. Based on his review, Dr. Castle opined Mr. Edwards does not have coal workers' pneumoconiosis because he "doesn't demonstrate consistent physical findings indicating the presence of coal workers' pneumoconiosis." Notably, the vast majority of chest x-ray interpretations are negative. Further, the pulmonary function tests disclose a mild airways obstruction with reversibility and gas trapping associated with a mild reduction in diffusion capacity. These test results are consistent with a tobacco induced airways obstruction. Likewise, the mild degree of hypoxemia upon exercise and the mild irregular radiographic abnormalities are indicative of respiratory bronchiolitis. This condition developed long after Mr. Edwards left coal mining but while he continued to smoke cigarettes. In Dr. Castle's opinion, Mr. Edwards is totally disabled due to cigarette smoking.

On May 17, 2005, Dr. Castle reviewed the newly developed medical evidence consisting of Dr. Forehand's May 2004 pulmonary examination and two negative chest x-ray interpretations of the May 2004 chest x-ray by Dr. Scott and Dr. Scatarige. For two reasons, Dr. Castle disagreed with Dr. Forehand's conclusions and diagnosis. First, contrary to Dr. Forehand's assertion, Dr. Castle opined that the pulmonary function test was not normal. Instead, the study revealed a mild obstruction associated with a reduction in diffusion capacity. Additionally, prior pulmonary function studies had demonstrated a significant reversibility following administration of a bronchodilator. These pulmonary function test results are indicative of a tobacco smoke induced airways obstruction. Second, also contrary to Dr. Forehand's radiographic interpretation, one radiologist found evidence of emphysema in the chest x-ray. Based on his review of the medical record, Dr. Castle opined that Mr. Edwards did not have coal workers' pneumoconiosis. His disabling blood gas deficiency was due to tobacco smoke induced "respiratory bronchiolitis interstitial lung disease." According to Dr. Castle, Dr. Forehand failed to even consider the possibility of this diagnosis.

Discussion

Over the course of nearly thirty years, the numerous physicians to evaluate Mr. Edwards' pulmonary condition disagreed on whether he had black lung disease. Dr. Baxter and Dr. Forehand concluded Mr. Edwards had black lung disease. On the other hand, Dr. Dahhan, Dr. Modi, Dr. Iosif, Dr. Fino, and Dr. Castle concluded that he did not have coal workers' pneumoconiosis.

In light of this conflict in medical opinion concerning the presence of pneumoconiosis, I must assess the respective probative value of these diverse assessments in terms of documentation and reasoning. As to the first factor, a physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation

that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter.

The second factor affecting relative probative value, reasoning, involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988).

Applying these two evidentiary standards, I give Dr. Baxter's assessment diminished probative weight due to documentation issues and a reasoning shortfall. Certainly, as Mr. Edwards' treating physician for many years, Dr. Baxter was in an excellent position to develop a well founded opinion regarding his pulmonary condition. However, other than one hospitalization in the early 1990s and a pulmonary evaluation, Dr. Baxter focused his medical expertise on other significant, non-pulmonary health issues. Further, despite his status as a treating physician, Dr. Baxter does not mention, or appear to even be aware of, the other pulmonary examinations, pulmonary tests and the extensive negative radiographic record developed over a couple of decades relating to Mr. Edwards' breathing problems. As a result, the breadth of Dr. Baxter's documentary foundation for his black lung diagnosis is limited. Additionally, Dr. Baxter's diagnosis of medical coal workers' pneumoconiosis is based on documentation inconsistent with my findings. Specifically, Dr. Baxter relied on a positive interpretation of an August 2003 chest x-ray to diagnose coal workers' pneumoconiosis. However, as previously discussed, I have determined that the August 1993 chest x-ray upon which he relied, as well as the profound preponderance of the radiographic evidence in the record, is actually negative for pneumoconiosis. Dr. Baxter also opined that Mr. Edwards' COPD was in part due to his exposure to coal dust. While that finding may satisfy the legal definition of coal workers' pneumoconiosis, Dr. Baxter provided no reasoning or explanation for his conclusion that the mild obstructive pulmonary impairment was related in part to Mr. Edwards' coal mine employment.

Dr. Dahhan's conclusion that Mr. Edwards did not have pneumoconiosis was reasoned and documented when he presented it in 1994. At that time, the pulmonary function testing and arterial blood gas studies were near normal. Since then, as demonstrated by abnormal arterial blood gas studies Mr. Edwards' respiratory capacity has diminished to the extent he has become totally disabled. Due to the dated nature of his evaluation, Dr. Dahhan understandably did not consider these significant more recent pulmonary tests. Consequently, his assessment has diminished probative value on the nature of Mr. Edwards' present pulmonary impairment.

Though Dr. Modi may have been Mr. Edwards' treating physician for a period of time, his sole hospitalization annotation that Mr. Edwards' had acute bronchitis provides little insight on the documentary basis for, and medical reasoning behind, his diagnosis. Consequently, Dr. Modi's notation has little probative weight.

Within the parameters of his 1997 evaluation of Mr. Edwards' pulmonary condition, Dr. Iosif's conclusion that he did not have pneumoconiosis is reasoned and documented. Nevertheless, his opinion shares the same probative infirmity as Dr. Dahhan's 1994 examination. Since Dr. Iosif was unaware of the subsequent development of Mr. Edwards' pulmonary impairment, his dated opinion is not particularly probative.

At this point, based on the above probative value findings, the determination of whether Mr. Edwards has pneumoconiosis requires resolving the professional opinion dispute between Dr. Forehand, Dr. Fino and Dr. Castle, the three physicians to most recently consider Mr. Edwards' disabling pulmonary impairment.

Turning first to Dr. Forehand, his two pulmonary examinations in 2003 and 2004 and purported treatment of Mr. Edwards provided a firm foundation for his evaluation.[52] However, two reasoning issues and a related documentary deficiency diminish the probative value of his assessment. First, Dr. Forehand includes a positive for pneumoconiosis chest x-ray interpretation as partial support for his diagnosis of coal workers' pneumoconiosis. However, because he also relies on the abnormal arterial blood gas study as a basis for this conclusion, his opinion avoids the probative shortfall encountered by Dr. Baxter. Nevertheless, Dr. Forehand provided no explanation for how he was able to isolate coal dust exposure rather than cigarette smoke as the cause for the blood oxygenation deterioration. Second, his lack of an explanation in that regard is further problematic because Dr. Forehand also did not address how the significant response to bronchodilator use in the June 2003 of 22%, and the variability between the pulmonary function test results in 2000, 2003, and 2004, which appears inconsistent with the permanent and irreversible damage caused by pneumoconiosis, fit into his diagnosis of pneumoconiosis. Regarding documentation, Dr. Forehand only appears to have considered his own positive interpretation of the chest x-rays. Apparently, he was not aware of disagreement among radiology experts on whether the films showed pneumoconiosis. Since he did not review that extensive record of negative chest x-ray interpretations, Dr. Forehand was not able to address how those assessments may have affected his certainty that coal dust exposure was the most likely cause of Mr. Edwards' recently developed arterial blood gas abnormality.

Next, Dr. Fino also based his conclusions on a firm documentary basis involving three record reviews in 1994, 2001, and 2004. However, Dr. Fino eliminates coal workers' pneumoconiosis as a possible cause of Mr. Edwards' breathing problem based on a rationale inconsistent with the statutory and regulatory definition of pneumoconiosis. In explaining how he was able to exclude pneumoconiosis as a possible etiology, Dr. Fino stressed that the recent deterioration in Mr. Edwards' blood oxygenation capabilities occurred only long after he left coal mining but while he continued to smoke cigarettes. While that reasoning may have a firm medical foundation and has logical appeal, an implication of that rationale is that if coal dust is going to adversely affect oxygenation capacity, the problem must develop while the claimant is

[52]Other than one pulmonary treatment visit, the record contains little evidence as to the frequency, extent, and depth of Dr. Forehand's contacts with Mr. Edwards. Consequently, I am unable to give Dr. Forehand's opinion enhanced status as a treating physician. Additionally, the record contains little indication that his diagnoses and opinions were based on his status as treating physician rather than the objective tests and medical evidence he specifically referenced

still exposed to coal dust. Yet, under the statute and implementing regulation, 20 C.F.R. § 718.201 (c) (2001), pneumoconiosis "is recognized as a *latent* and progressive disease which may *first* become detectable *only after the cessation of coal mine dust exposure*" (emphasis added). Since Dr. Fino's reasoning seems to eliminate the possibility of latent development of pneumoconiosis in Mr. Edwards' case, his elimination of coal workers' pneumoconiosis as a pulmonary condition has diminished probative value.

Finally, due to his exhaustive reviews of the medical record and his two pulmonary evaluations of Mr. Edwards in 1997 and 2000, Dr. Castle presented the best documented assessment in the record. Based on this extensive documentation, he was well aware of the preponderance of the radiographic interpretation, the variability both within and between the pulmonary function test results, and the deteriorating arterial blood gas studies. Relying on this documentation, Dr. Castle presented an extensive and detailed explanation for his conclusion that Mr. Edwards does not have pneumoconiosis. Yet, after acknowledging his understanding of the medical and legal definitions of pneumoconiosis, including its defined progressive nature, Dr. Castle still stated that it was "virtually impossible" for Mr. Edwards to develop pneumoconiosis after his 1997 examination absent further exposure to coal dust. Dr. Castle specifically highlighted that Mr. Edwards' oxygenation deficiency developed long after he left coal mining. Again, while reasonable under many standards, Dr. Castle's statement is clearly inconsistent with the regulatory definition of pneumoconiosis. As a result, that portion of his reasoning diminishes the probative value of his analysis in the same manner Dr. Fino's conclusion lost probative value. I also note at least one troubling internal inconsistency in Dr. Castle's discussion. In an early consideration of Mr. Edwards' case, Dr. Castle stressed that the June 2003 pulmonary function test showing significant reversibility upon use of a bronchodilator was inconsistent with the permanent and irreversible damage caused by coal workers' pneumoconiosis. Yet, in 2005, after reviewing Dr. Forehand's most recent pulmonary evaluation from May 2004, Dr. Castle didn't discuss whether that more recent pulmonary function test which showed little of the earlier reversibility might alter his determination that Mr. Edwards didn't have pneumoconiosis.[53] Consequently, despite a solid documentation basis, due to these noted reasoning issues, Dr. Castle's determination has diminished probative value.

In summary, due to the dated nature of many of the medical opinions, only the most three recent assessments by Dr. Forehand, Dr. Fino, and Dr. Castle had the potential to provide definitive, probative conclusions about the nature of Mr. Edwards' present pulmonary deterioration. For various reasons, each of these respective opinions has diminished and insufficient probative value. Since Mr. Edwards bears the burden of proof in this case, this ultimate dearth of probative medical opinion supporting a finding of pneumoconiosis means he is unable to prove by the preponderance of probative medical opinion the presence of pneumoconiosis under 20 C.F.R. § 718.202 (a) (4).

[53]The difference in the degree of reversibility following the use of bronchodilators between the two tests shows a different type of variability that might still have provided support for Dr. Castle's analysis. However, Dr. Castle failed to even mention the noticeable change in reversibility between the 2003 and 2004 pulmonary function tests.

Compton Analysis

Under the guidance of the decision in *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), I must also consider both the chest x-ray evidence and medical opinion together to determine whether Mr. Edwards has pneumoconiosis. In that regard, since standing alone neither the preponderance of the chest x-rays nor the medical opinion established the presence of pneumoconiosis, consideration of that evidence together obviously still fails to produce a finding of pneumoconiosis.

CONCLUSION

Based on the most recent exercise arterial blood gas studies which met the total disability standards, Mr. Edwards has demonstrated that a material change in his pulmonary condition has occurred since Judge Murty's affirmed denial of his prior claim. However, upon consideration of the entire record, I find the preponderance of the radiographic evidence is negative for pneumoconiosis. Similarly, in the absence of a sufficiently probative medical assessment, Mr. Edwards is unable to establish the presence of pneumoconiosis through medical opinion. Accordingly, having failed to prove the first requisite element of entitlement, the presence of pneumoconiosis, Mr. Edwards' claim for black lung disability benefits must be denied.

ORDER

The black lung disability benefits claim of MR. LARRY V. EDWARDS is **DENIED**.

SO ORDERED:

A

RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: January 25, 2006
Washington, DC

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board. After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed. At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481. If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

Attachment No. 1

American Board of Medical Specialties

Certification:

John C. Scatarige, MD

Certified by the American Board of Radiology in:

Radiology

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